



## CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

March 17, 1999

### **S. 326**

### **Patients' Bill of Rights Act**

*As introduced on January 28, 1999*

#### **SUMMARY**

Title I of the Patients' Bill of Rights Act would amend the Employee Retirement Income Security Act (ERISA) to give members of self-insured health plans rights to obtain certain services, require group health plans and health insurance issuers to provide certain information to enrollees and potential enrollees, and establish internal and external review procedures for group health plans and health insurance issuers. Title II would require all health plans, health care providers, and other entities to protect the confidentiality of health information and would allow individuals to inspect and copy their own medical records. Title III would prohibit health plans from discriminating on the basis of genetic information. Title IV would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality and would reauthorize the agency.

The proposed patient protections and grievance procedures would increase the premiums for employer-sponsored health insurance, substitute non-taxable fringe benefits for taxable wages, and reduce federal receipts from income and payroll taxes. The Congressional Budget Office (CBO) estimates that these provisions would reduce federal tax revenues by \$20 million in 2000 and by \$0.5 billion over the 2000-2004 period.

#### **ESTIMATED COST TO THE FEDERAL GOVERNMENT**

The estimated effect of the bill on direct spending and receipts is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

Table 1. Estimate of the Budgetary Effects of S. 326, Patients' Bill of Rights Act

	By fiscal year, in billions of dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>Revenues</b>										
Income and HI Payroll Taxes	a	a	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Social Security Payroll Taxes	<u>a</u>	<u>a</u>	<u>a</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.1</u>
Total	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3
<b>Authorizations of Appropriations</b>										
Healthcare Research and Quality	a	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.1	a

SOURCE: Congressional Budget Office.

NOTE: HI = Hospital Insurance.

a. Less than \$50 million.

## BASIS OF ESTIMATE

### Revenues

The proposed rights to medical care and advice, informational requirements, and grievance procedures would affect the federal budget through their effect on premiums for employer-sponsored health insurance. Although the rights to medical advice and care would apply only to self-insured ERISA plans, other plans are likely to be affected by them as well. Federal legislation to regulate a significant part of the health insurance market could stimulate action on the part of both states and health plans to develop consistent policies on coverage. Taking such spillover effects into account, CBO estimates that the provisions for medical care and advice, patient information, grievance procedures, and confidentiality of patient information would raise average premiums by about 0.5 percent. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.

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**TABLE 2. ESTIMATED EFFECT OF THE PATIENTS’ BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percents)**

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Provision	Increase in Premiums
<b>Title I</b>	
Subtitle A—Right to Medical Advice and Care	
Access to emergency care	0.1
Offering choice of coverage options	0.1
Access to obstetric and gynecological care	a
Access to pediatric care	a
Continuity of care	0.1
Protection of patient-provider communications	a
Subtitle B—Right to Information About Plans and Providers	0.1
Subtitle C—Right to Hold Health Plans Accountable	0.1
<b>Title II</b>	
Personal Medical Information	a
<b>Title III</b>	
Genetic Information and Services	<u>a</u>
Total	0.5

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a. Less than 0.05 percent.

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The estimate assumes that about 60 percent of the increase in premiums would be offset through decreases in fringe benefits and that about 40 percent would be passed on to employees as lower wages. CBO estimates that the increase in premiums would reduce federal tax revenues by \$20 million in 2000 and by \$0.5 billion over the 2000-2004 period. Social Security payroll taxes, which are off-budget, account for about \$160 million of the five-year total.

**Right to Medical Advice and Care.** Subtitle A of title I contains a number of patient protections for enrollees in self-insured ERISA health plans. Those provisions include a prohibition against interference by health plans with medical communications between physicians and their patients, a requirement that plans pay for hospital emergency visits when the prudent layperson standard is met, a requirement for direct access to an obstetrical and

gynecological specialist for covered routine obstetrical and gynecological care, a requirement for direct access to pediatricians for covered routine pediatric services, the right to continue care for 90 days with a provider whose contract has been terminated by a health plan, and a requirement that health plans offer employees a point-of-service option when the existing health plan offerings do not provide choice among provider groups. CBO estimates that these rights to medical care and advice would ultimately increase costs across all nonfederal employer-sponsored health plans by about 0.1 percent.

**Right to Information About Plans and Providers.** Subtitle B of title I would require all ERISA group health plans to provide certain kinds of information on plan provisions to enrollees and to make other kinds available on request. Most of the required information is typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although some documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. Plans would be responsible for making available to participants any data on quality or performance that they collect, but they would not be required to collect such data. Plans would have to make minor investments in personnel and systems to assure and monitor compliance with those requirements. CBO estimates that the informational requirements would increase costs across all nonfederal employee sponsored health plans by slightly less than 0.1 percent.

**Right to Hold Health Plans Accountable.** Subtitle C of title I would require all ERISA group health plans to abide by specific time limits for making coverage determinations and to have an internal review process for reconsidering coverage decisions within defined time limits at the request of the enrollee. For those coverage decisions involving medical necessity or investigational treatments, a physician with the appropriate expertise would have to conduct the internal review. Plans would also have to provide for external review of medical necessity decisions involving claims exceeding a significant dollar threshold or investigational treatments for life threatening illnesses. The findings of the external review would be binding on the health plan.

Most plans today have a functioning internal appeals process, but they operate with more flexibility on timing than they might have under this provision. Consequently, a few plans would have to invest in more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review, which would be new to most plans. CBO estimates that the net cost of this subtitle would be 0.1 percent of employer-sponsored health plan costs.

**Personal Medical Information.** Title II would require health care providers, health plans, employers, health or life insurers, schools, and universities to provide a patient with access

to his or her medical records and allow the patient to request amendments to the record. These entities, as well as health oversight agencies, public health authorities, and health researchers would have to provide a written statement of their confidentiality policies. Along with law enforcement officials, they would also be required to implement appropriate safeguards to protect the confidentiality of individually identifiable health information.

The provisions regarding access to medical records would impose small administrative costs, most of which could be passed on to the requestor of the information through fees. The requirements for the protection of the confidentiality of health information might impose small costs on entities that do not already have such safeguards in place. CBO estimates that these provisions would increase premiums by less than 0.05 percent.

**Genetic Information and Services.** Title III would prohibit all health plans and health insurers from using predictive genetic information in setting premiums for groups or individuals. It would also prohibit plans from requesting such information except when the information was needed for diagnosis, treatment, or payment relating to the provision of health services. Even then, plans could not require such information and would have to provide the individual with a description of the procedures in place for protecting the confidentiality of such information. Although this provision would keep health insurers and health plans from reducing their costs through favorable risk selection based on genetic information, its cost to private employer-sponsored health plans as a whole would be negligible.

## **Authorizations of Appropriations**

**Healthcare Research and Quality.** Title IV would redesignate the Agency for Healthcare Policy and Research as the Agency for Healthcare Research and Quality and respecify its mission. To support the activities of AHRQ, S. 326 would authorize \$185 million in fiscal year 2000 and such sums as may be necessary for fiscal years 2001-2006. Assuming appropriations of the authorized amounts, CBO estimates that this title would increase discretionary spending by about \$20 million in fiscal year 2000 and \$660 million over the 2000-2004 period.

## PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending and receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in Table 3. For purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 3. Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in outlays	0	0	0	0	0	0	0	0	0	0
Change in receipts	-20	-60	-100	-150	-200	-240	-250	-270	-280	-300

## ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 326 would amend ERISA and the Public Health Service Act to establish a number of new requirements governing health care benefits and insurance. However, plans offered by state, local, and tribal governments are exempt from ERISA, and those governments would be able to opt out of the requirements under the Public Health Service Act. Consequently, these provisions would not be intergovernmental mandates as defined by UMRA, and they would have an impact on the budgets of state, local, or tribal governments only if those governments chose to comply.

S. 326 would require entities that provide health care services to permit an individual to inspect and copy protected health care information, with some exceptions regarding life and safety issues and confidentiality of external sources. The requirement to provide access would be an intergovernmental mandate for governmental health care providers. However, the cost of providing access to records would likely be minimal. The costs of copying the information could be passed on to the individual.

## **ESTIMATED IMPACT ON THE PRIVATE SECTOR**

The bill would impose several private-sector mandates as defined in UMRA. They include the rights to medical care and advice, requirements to safeguard and grant patients access to their medical records, and requirements for plans to establish appeals procedures for handling patients' grievances. CBO estimates that the direct costs of those mandates to private-sector entities would significantly exceed the threshold specified in UMRA (\$100 million in 1996, adjusted annually for inflation) every year after 2000.

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